Name:
ID#:

HOW AM I DOING?
YOUR CHILD 12 MONTHS THROUGH 6 YEARS
RISK ASSESSMENT

If you have any questions or concerns about yourself or your child, please share these with your child's health care provider. We want to assist you with your needs anyway possible.

YES	NO		
☐	☐	1.	Has your child had contact with person with confirmed or suspected infectious tuberculosis. (Family member or associate in jail or prison)
☐	☐	2.	Has your child had an x-ray or examination that may suggest tuberculosis?
☐	☐	3.	Has your child emigrated from a foreign country where there is a history of tuberculosis? (Asia, Middle East, Africa, Latin America)
☐	☐	4.	Has your child traveled to a foreign country or had contact with a native person from such a country where there is a history of tuberculosis?
☐	☐	5.	Does your child have HIV/AIDS?
☐	☐	6.	Has your child or does your child live in a group home, foster care, or orphanage?
☐	☐	7.	Are you concerned that someone will harm you or your child, or worry that you will harm someone?
☐	☐	8.	Has your partner or someone important to you emotionally, physically, or sexually abused you or your child?
☐	☐	9.	Does your child ever threaten to harm him/herself?
☐	☐	10.	Does your child live in or visit a house with peeling or chipping paint built before 1950? (Daycare, preschool, baby-sitter, or relative, etc.)
☐	☐	11.	Does your child live in or visit a house built before 1978 with recent, ongoing, or planned renovations or remodeling?
☐	☐	12.	Does your child have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (blood level at or above 20ug/dl)?
☐	☐	13.	Does your child live with an adult whose job or hobby involves exposure to lead? (Lead batteries, firing range, chemicals & chemical preparations, bridge, tunnel, elevated highway construction, etc.)
☐	☐	14.	Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
☐	☐	15.	Have you seen your child eating paint chips or dirt? Chew on any painted surfaces?
☐	☐	16.	Do you or the child's parents do migrant farm work?
☐	☐	17.	Does your child receive any home or folk remedies that may contain lead?
		18.	What type of water does your child drink daily? **(Circle all that apply for your child):**

City Well Cistern Bottled Water

19. Does your child do or attempt to **(circle those that apply under age of your child)**:

12 MO.	15 MO.	18 MO.	24MO.
Cruise (walk or crawl)	Walk Well	Run Stiffly	Climb Up & Down Stairs
Pull to Stand	Climb	Roll a Ball	Kick a Ball Forward
Take Steps	Stack 2 Blocks	Scribble	Circular Crayon Strokes
Bang Blocks Together	Speak 3 to 6 words	Mimic Words	Stack 5-6 Blocks
Imitate Sounds	Speak in 2 Word Phrases	Name Objects	Use 2-3 Word Phrases
Say "Bye" & "No"	Listen to Story	Speak 15 – 20 Words	Follow 2-Step Commands
Play Pat-a-cake	Use a Cup	Blow Kisses	Imitate Adults
Wave Bye-Bye	Make Gestures (point, shake head)	Use Spoon/Fork	Remove Clothes

3 YR.	4 YR.	5 YR.	6 YR.
Jump Up & Down	Hop on 1 Foot	Skip	Heel to Toe Steps
Throw Ball	Throw Overhand	Balance on 1 foot 5 sec.	Draw 6 Part Man
Copy Circles & Crosses	Wiggle his/her Thumb	Draws 3 Part Man	Know All Letters of the Alphabet
Know Name, Age, & Sex	Sing Songs	Knows Address & Phone	Count Numbers
Use 3-4 Word Phrases	Be aware of Self/Others	Dresses Without Help	Understand Right/Wrong

YES	NO	
☐	☐	20. Do you have concerns about your child's weight or eating habits?
☐	☐	21. Does your child follow a special diet or is on a prescribed medication?
☐	☐	22. Does your child eat or drink every day: **(circle all that apply)** Fried Foods Lunch Meats Soft Drinks Cake Cookies Chips
☐	☐	23. Does your child eat 6 servings of any of the following daily: bread, cereal, rice, or pasta?
☐	☐	24. Does your child eat 3 servings of vegetables each day?
☐	☐	25. Does your child eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?
☐	☐	26. Does your child eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup, beans, eggs or peanut butter?
☐	☐	27. Does your child eat or drink 3 servings daily of any of the following: milk, cheese or yogurt?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

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_____

_____

ENTIRE FORM HAS BEEN REVIEWED AND UPDATE WITH PATIENT ON FOLLOWING DATES: (SIGNATURE AND DATE REQUIRED)

_____ _____

_____ _____

_____ _____

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Reference: Maternal and Child Health Bureau, *Bright Futures Guidelines for Health Supervision of Infants, Children, And Adolescents*, National Center for Education in Maternal and Child Health, 1994, Arlington, VA.